INSTRUCTIONS FOR COMPLETING
The Model Application Template for
State Child Health Plan Under Title XXI of the Social Security Act
State Children's Health Insurance Program

Preamble. Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children=s Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Blvd., Baltimore, MD 21244.

Instructions for the Model Application Template for the State Children=s Health Insurance Program

Introduction. The purpose of the State Children=s Health Insurance Program (Title XXI) is to provide Federal matching funds to states to enable them to initiate and expand coverage to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. States are able to use Title XXI funds for: (1) obtaining health benefit coverage, (2) expanding Medicaid coverage, or (3) a combination of both.

Requirement to Submit a State Plan. In order to be eligible for payment under this legislation, each state must submit a Title XXI plan for approval by the Secretary that details how the state intends to use the funds and fulfill other requirements under the law and regulations. Under the law, a state plan is considered approved in 90 days unless the Secretary notifies the state in writing that the plan is disapproved or that specified additional information is needed. If a state wishes to use Medicaid to expand coverage through Title XXI, it must submit a Medicaid plan amendment for an eligibility expansion in addition to submitting a state plan for Title XXI. The Title XXI plan should encompass all of the child health assistance being provided using Title XXI funding. The Department will be working with states to facilitate and expedite the application and approval process.

Any items that require a description may be addressed in the form of an attachment or in the space provided. It is expected that any attachments will be brief and limited to one page, unless more space is needed for an accurate description.

The application template includes the following sections:
1.General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements
2.General Background and Description of State Approach to Child Health Coverage and Coordination
3.Methods of Delivery and Utilization Controls
4.Eligibility Standards and Methodology
5.Outreach
6.Coverage Requirements for Children=s Health Insurance
7.Quality and Appropriateness of Care
8.Cost Sharing and Payment
9.Strategic Objectives and Performance Goals and Plan Administration
10.Annual Reports and Evaluations
11.Program Integrity
12.Applicant and Enrollee Protections
Glossary

Statement of Purpose. This model application template and instructions may be employed by states for the purpose of submitting a state plan or plan amendment. When submitting a state plan amendment, states should redline and strikeout the changes that are being made to the existing state plan. The instructions have been designed to complement the model application template and to facilitate completion of the template. States should use the instructions in conjunction with the template for guidance regarding what issues should be addressed in the narrative sections of the state plan.

With regard to Sections 9 and 10 on performance goals and annual reporting requirements, we plan on developing national standards for performance measures, in conjunction with the states, and other interested parties, subsequent to the implementation of this legislation. We believe that, by developing national standards with the states, and others, we will insure the ability to review and evaluate the impact of the program in a way that will be most useful to the public, while limiting the reporting burdens on the states, and ensuring accountability and effectiveness of State programs.

Program Options. As mentioned above, the law allows states to expand coverage for children through a separate child health insurance program, through the Medicaid program, or through a combination of these programs. States have the following options under Title XXI:

> **Option to Expand Medicaid.** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under state rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.
>
> **Option to Create or Expand a Separate Program.** States electing to use their available Title XXI funds to establish or expand a separate child health program will be subject to new cost-sharing and benefit rules in the law. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid. The law requires that any state that lowers its Medicaid eligibility standards for children below the June 1, 1997 levels be denied access to the child health funds.
>
> **Combination of Options.** The law allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a state may cover children in families with incomes of up to 133% of poverty through Medicaid and a targeted group of children above that level through a separate program. For the children the state chooses to cover under Medicaid, the description provided under AOption to Expand Medicaid≅ would apply. Similarly, for children the state chooses to cover under a separate program, the provisions outlined above in AOption to Create or Expand a Separate Program≅ would apply.

Instructions for the Model Application Template for the State Children=s Health Insurance Program

In order to expedite the application process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete **Sections 1 (General Description), 2 (General Background), 5 (Outreach), 9 (Strategic Objectives and Performance Goals and Plan Administration), and 10 (Annual Reports and Evaluations)**. States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX state plans. These states may complete the first check-off for Sections 3 (Methods of Delivery and Utilization Controls), 4 (Eligibility Standards and Methodology), 6 (Coverage Requirements for Children's Health Insurance), 7 (Quality and Appropriateness of Care), 8 (Cost Sharing and Payment), 11 (Program Integrity) and 12 (Applicant and Enrollee Protections) indicating that the description of the requirements for these sections are incorporated by reference through their state Medicaid plans. States wishing to use a combination of approaches will be required to complete the Title XXI state plan and the necessary state plan amendment under Title XIX.

Completed state plans and plan amendments for Title XXI should be submitted to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244

Attn: Family & Children's Health Programs Group
Center for Medicaid and State Operations
Mail Stop - S2-01-16

The state should submit the plan electronically, followed by 3 hard copies. If submitted only in hard copy, the state should submit an original package and 20 copies. The CMS Regional Office for your area should also be sent three (3) copies of the plan (one copy if submitted electronically or on disk) at the same time it is submitted to CMS Central Office. Plans may be submitted on computer disk, formatted using Microsoft Word. An electronic version of the model application template can be obtained by contacting CMS . The template and instructions can be downloaded from the CMS website (Http://www.CMS.gov). Questions regarding this process may be submitted to the Division of State Children=s Health Insurance or the state may contact its servicing Centers for Medicare & Medicaid Services regional office. The contacts and addresses for the regional offices are as follows:

CMS Associate Regional Office Administrators

Regional Office	Associate Administrator	Address	Phone
Atlanta	Gene A. Grasser, Jr.	Atlanta Federal Center 61 Forsyth Street, S.W., Suite 4T20 Atlanta, Georgia 30303-8909	404-562-7401
Boston	Ronald P. Preston	John F. Kennedy Federal Building Room 2325 Boston, Massachussetts 02203-0003	617-565-1223
Chicago	Cheryl Harris	233 North Michigan Avenue, Suite 600 Chicago, Illinois 60601	312-353-2702
Dallas	Calvin Cline	1301 Young Street, 8th Floor Dallas, Texas 75202	214-767-6301
Denver	Spencer Ericson	Federal Office Building, Room 522 1961 Stout Street Denver, Colorado 80294-3538	303-844-1977
Kansas City	Tom Lenz	Richard Bolling Federal Buidling 601 East 12 Street, Room 235 Kansas City, Missouri 64106-2808	816-426-5925
New York	Sue Kelly	26 Federal Plaza Room 3811 New York, New York 10278-0063	212-264-2058
Philadelphia	Claudette V. Campbell	Suite 216, The Public Ledger Building 150 South Independence Mall West Philadelphia, Pennsylvania 19106	215-861-4263
San Francisco	Karen Fuller	75 Hawthorne Street, 4th and 5th Floors San Francisco, California 94105-3903	415-744-3576
Seattle	Teresa Trimble	2201 Sixth Avenue, MS/RX-40 Seattle, Washington 98121-2500	206-615-2313

SECTION SPECIFIC INSTRUCTIONS (For attached model application template)

Section 1. General Description and Purpose of the State Child Health Plan and State Child Health Plan Requirements

Introduction

An approved state child health plan is required in order for a state to be eligible for payment under Title XXI. This plan must set forth how the state intends to use the funds provided under Title XXI by indicating that child health assistance shall be provided primarily through one of the three options listed in Section 2101(a) of the Social Security Act (the Act). **(42 CFR, 457.70))**:

Guidance

Section 1.1.

X 1.1.1 Check here if child health assistance shall be provided primarily through the development of an independent insurance program that meets the requirements of Section 2103, which details coverage requirements and the other applicable requirements of Title XXI.

X 1.1.2 Check here if child health assistance shall be provided primarily through providing expanded eligibility under the state=s Medicaid program (Title XIX).

X 1.1.3 Check here if child health assistance shall be provided through a combination of both 1.1. and 1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the state=s Medicaid program).

Section 1.2 Please provide an assurance that the State will not claim expenditures for child health assistance prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR, 457.40(d))**

Section 1.3 States must operate State plans and plan amendments in accordance with Federal civil rights laws, and we require in ∋457.130 that a State provide an assurance in its State plan that it will comply with all applicable civil rights requirements. Please provide an assurance that the state complies with all applicable civil rights requirements. **(42CFR, 457.130)**

Section 1.4 This section asks states to provide both the effective and implementation dates for the state plan or plan amendment. Effective date is defined as

the date on which the state begins to incur costs to implement its state plan or amendment. **(42 CFR, 457.65)**

Implementation date is defined as the date the state begins to provide services; or, the date on which the state puts into practice the new policy described in the state plan or amendment. For example, in a state that has expanded eligibility, this is the date on which the state begins to provide coverage to enrollees (and not the date the state begins outreach or accepting applications).

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination

Introduction

This section is designed to solicit general information related to the special characteristics of each state. The information being sought concerns the extent and manner to which children in the state currently have creditable health coverage, current state efforts to provide or obtain creditable health coverage for uncovered children and how the plan is designed to be coordinated with current health insurance or public health efforts. This information will provide a health insurance baseline in terms of the status of the children in a given state and the state programs currently in place.

Guidance

Section 2.1. The demographic information requested in 2.1. can be used for state planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT. The numbers used to determine the allotment of funds under Title XXI will be those provided each year by the U.S. Bureau of the Census.

Factors that the state may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. To the extent practicable, the state should make a distinction between creditable coverage under public health insurance programs (e.g., Medicaid and state-only child health insurance) and public-private partnerships, and describe its information sources and the assumptions it uses for the development of its description. **(42 CFR, 457.80(a))**

Section 2.2. A state child health plan must include an overview of current efforts made by the state through child related programs (e.g., Medicaid, the Maternal and Child Health Block Grant, Title V, WIC, community and migrant health centers, or special state programs for child health care) to provide health care services or obtain creditable health coverage for uncovered children by identifying and enrolling all uncovered children. **(42CFR, 457.80(b))**

X 2.2.1. Briefly describe the steps being taken by the state to identify and enroll all uncovered children who are eligible to participate in ***public*** health insurance programs (e.g., Medicaid and state-only child health insurance). This information may include a description of the state's outreach efforts through Medicaid and state-only programs.

X 2.2.2. Briefly describe the steps being taken by the state to identify and enroll all uncovered children eligible to participate in health insurance programs that involve a ***public-private*** partnership. The state may also address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide an historic record of the steps the state is taking to identify and enroll all uncovered children at the time the state=s plan was initially approved.

Section 2.3. This item requires a brief overview of how new Title XXI efforts -- particularly new enrollment outreach efforts -- will be coordinated with and improve upon existing state efforts described in Section 2.2.

To help understand the strategy of the state plan to accomplish the intent of Title XXI, states need to describe the efforts they are making to coordinate the Title XXI plan with the Medicaid program. **Under Title XXI children identified as Medicaid-eligible are required to be enrolled in Medicaid.** Therefore, the state should describe how its Title XXI program will closely coordinate the enrollment with Medicaid. We note that specific information related to Medicaid Ascreen and enroll≅ procedures is requested in Section 4.4. States should also show how they will coordinate with other public and private programs, such as title V, that provide creditable coverage for low-income children. **(42CFR, 457.80(c))**

Section 3. Methods of Delivery and Utilization Controls

Introduction

The state child health assistance plan must describe the type of child health assistance to be provided under the plan (2102(a)(4)). This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers.

****Note: States electing to use funds provided under Title XXI only to provide expanded eligibility under the state=s Medicaid plan may check the appropriate box and proceed to Section 4.**

Guidance

Section 3.1. In describing the methods of delivery of the child health assistance using Title XXI funds, the state must address the choice of financing the insurance products and the methods for assuring delivery of the insurance product(s) and delivery of health care services covered by such products to enrollees, including any variations. These may include, but are not necessarily limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The state should describe any variations based upon geography, as well as the state methods for establishing and defining the delivery systems.

In addition, states may use up to 10 percent of actual or estimated Federal expenditures for targeted low-income children to fund other forms of child health assistance, including contracts with providers for a limited range of direct services; other health services initiatives to improve children=s health; outreach expenditures; and administrative costs (See 2105(a)(2)). Describe which, if any, of these methods will be used.

Examples of the above may include: direct contracting with school-based health services; direct contracting to provide enabling services; contracts with health centers receiving funds under section 330 of the Public Health Service Act; contracts with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Act; contracts with other hospitals; and contracts with public health clinics receiving Title V funding.

If applicable, address how the new arrangements under Title XXI will work with

existing service delivery methods, such as regional networks for chronic illness and disability; neonatal care units, or early-intervention programs for at-risk infants, in the delivery and utilization of services. **(42CFR, 457.490(a))**

Section 3.2. In describing the utilization controls under the child health assistance using Title XXI, note that utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving heatlh care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but may not be limited to, the following: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the state should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and state developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. **(42CFR, 457.490(b))**

Section 4. Eligibility Standards and Methodology

Introduction

The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. Included on the template is a list of potential eligibility standards. Please check off the standards that will be used by the state and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, describe how they will be applied and under what circumstances they will be applied.

****Note: States electing to use funds provided under Title XXI only to provide expanded eligibility under the state=s Medicaid plan may check the appropriate box and proceed to Section 5.**

Guidance

Section 4.1. Check all standards that will apply to the state=s plan. **(42CFR 457.305(a) and 457.320(a))**

X	4.1.1. If eligibility criteria will vary based on geography within the state, check and explain.
X	4.1.2. Identify and explain the state=s age standards.
X	4.1.3. Identify the state=s income standards, including the definition of household and family income, deductions, disregards, and methods for evaluating family income.
X	4.1.4. Identify the state=s resource standards and describe spend down and disposition of resources, if applicable.
X	4.1.5. Identify the state=s residency requirements (so long as residency requirement is not based on length of time in state).
X	4.1.6. Identify how disability status affects eligibility.
X	4.1.7. Identify how access to or coverage under other health coverage affects eligibility.
X	4.1.8. Specify the duration of eligibility.
X	4.1.9. Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above.

Section 4.2. Assurances. The state must assure that its eligibility standards do not

discriminate on the basis of diagnosis; within a defined group of covered targeted low-income children, the standards do not cover children of higher income families without covering children with a lower family income; and the standards do not deny eligibility based on a child having a pre-existing medical condition. Check the appropriate boxes to make the necessary assurances. The state should review its policies and maintain state records necessary to explain how it may make these assurances. **(42CFR, 457.320(b))**

Section 4.3. Methodology. Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the state uses the same application form for Medicaid and/or other public benefit programs. **(Section 2102)(b)(2)) (42CFR, 457.350)**

X 4.3.1 This section asks for a description of the processes, if any, that a state will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box indicated and proceed. **(Section 2106(b)(7)) (42CFR, 457.305(b))**

Section 4.4. This section addresses eligibility screening and coordination with other health coverage programs. In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The state should consider including in this description important definitions, the relationship with affected Federal, state and local agencies, and other applicable criteria that will describe the state=s ability to make assurances.

States must describe how they will assure that: **(Sections 2102)(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))**

X 4.4.1. only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a state health benefits plan) are furnished child health assistance under the plan; **(Sections 2102)(b)(3)(A), 2110(b)(2)(B)) (42 CFR, 457.310(b), 42CFR 457.350(a)(1) and 457.80(c)(3))**

X 4.4.2. children found through the screening process to be potentially eligible for medical assistance under the state Medicaid plan are enrolled for assistance under such plan; **(Section 2102)(b)(3)(B)) (42CFR, 457.350(a)(2))**

X 4.4.3. children found through the screening process to be ineligible for Medicaid are enrolled in SCHIP; **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR, 431.636(b)(4))** (*Previously 2.4)*

X 4.4.4 the insurance provided under the state child health plan

does not substitute for coverage under group health plans; states should check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR, 457.805) (42CFR, 457.810(a)-(c))**

X 4.4.4.1. Coverage provided to children in families at or below 200% FPL: Describe the methods the state will use to monitor substitution.

X 4.4.4.2. Coverage provided to children in families over 200% and up to 250% FPL: Describe how the state will monitor substitution and identify specific strategies that will be put into place to limit substitution if monitoring shows that levels of substitution are becoming unacceptable. Identify the level at which these strategies will be implemented.

X 4.4.4.3. Coverage provided to children in families above 250% FPL: Describe how the state will monitor substitution and identify specific strategies in place to prevent substitution.

X 4.4.4.4. If the state provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined.

X 4.4.5 the provision of child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

Section 5. Outreach

Introduction

This section is designed for the state to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. **(Section 2102(c)(1)) (42CFR, 457.90)**

Guidance

Describe how the outreach program will be used to target children in the state likely to be eligible for child health assistance under the plan or under other private or public heatlh coverage programs (e.g., MCH Block Grant or WIC.). The description should include information on how the state will inform these populations of the availability of the programs and assist them in enrolling in the programs.

Outreach strategies may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

This section may also include discussions of the following:

- X How the outreach program will take advantage of the outreach strategies and experience of traditional safety net providers.
- X Coordination of the outreach program with other public and private health services, other social services, day care programs, and school-based or school-linked services.
- X Special outreach efforts that will target families of migrants, homeless children, other children with special health care needs, or those in rural or frontier areas.
- X Further outreach efforts the state will require of health plans or providers who receive Title XXI funds.

Section 6. Coverage Requirements for Children=s Health Insurance

Introduction

Regarding the required scope of health insurance coverage in a state plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage).

Identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions.

****Note: States electing to use funds provided under Title XXI only to provide expanded eligibility under the state=s Medicaid plan may check the appropriate box and proceed to Section 7.**

Guidance

Section 6.1. Check all that apply in terms of the coverage to be offered to eligible children. **(42CFR, 457.410(a))**

X 6.1.1. **Benchmark coverage** is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, state employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If this box is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked and an attached description provided. **(Section 2103(a)(1))**

X 6.1.1.1. Check here if the benchmark benefit package to be offered by the state is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. If checked, attach a copy of the plan. **(Section 2103(b)(1))**

X 6.1.1.2. Check here if the benchmark benefit package to be offered by the state is state employee coverage, meaning a coverage plan that is offered and generally available to state employees in the state. Identify the specific state plan and attach a copy of the benefits description. **(Section 2103(b)(2))**

X 6.1.1.3. Check here if the benchmark benefit package to be offered by the state is offered by a health

maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. Identify the specific HMO coverage plan and attach a copy of the benefits description. **(Section 2103(b)(3))**

X 6.1.2. **Benchmark-equivalent coverage** must meet the following requirements: the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430: inpatient and outpatient hospital services, physicians= surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age-appropriate immunizations and emergency services; the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, state employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430: coverage of prescription drugs, mental health services, vision services and hearing services.

If this box is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The state must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the state=s results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the state child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a state to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the state child health plan that results from the

limitations on cost sharing under such coverage. **(Section 2103(a)(2))**

X 6.1.3. **Existing comprehensive state-based coverage** is only applicable to New York, Florida and Pennsylvania. If this box is checked, an attached description of the benefits package, administration and date of enactment must be attached.

A state approved under this provision, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If Aexisting comprehensive state-based coverage≅ is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached.

Also, the fiscal year 1996 state expenditures for Aexisting comprehensive state-based coverage≅ must be described in the space provided for all states. **(Section 2103(a)(3))**

X 6.1.4. **Secretary-approved coverage** refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. **(Section 2103(a)(4)) (42 CFR 457.250)**

6.1.4.1 Check here if the coverage offered is the same as the coverage provided under the state=s Medicaid benefit package as described in the existing Medicaid state plan.

6.1.4.2 Check here if the coverage offered is comprehensive coverage for children offered under a Medicaid ∋1115 demonstration project.

6.1.4.3 Check here if the coverage offered includes the full Eearly and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit or that the state has extended to the entire Medicaid population in the state.

6.1.4.4 Check here if the coverage offered includes benchmark coverage, as specified in ∋457.420, plus additional coverage. Under this option, the state must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.5 Check here if the coverage is the same as the coverage provided under ∋457.440, Aexisting comprehensive state-based coverage.≅

6.1.4.6 Check here if the state is purchasing coverage through a group

health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in ∋457.420, through use of a benefit-by-benefit comparison of the coverage. Please provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in ∋457.431 to determine actuarial equivalence.

6.1.4.7 Check here if the state elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

Section 6.2. The term Achild health assistance≅ means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the services and products listed in this section of the template. All forms of coverage that the state elects to provide to children in its plan must be checked. The state should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. **(Section 2110(a)) (42CFR, 457.490)**

X 6.2.1. - 6.2.28. Check each box the state elects to provide coverage for in its child health assistance plan.

The following are clarifications of certain types of services:

X 6.2.14. Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

X 6.2.15. Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

X 6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by state law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by state law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a state or local government or is licensed under state law and operating within the scope of the license.

X 6.2.27. Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

Section 6.3. Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the state provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2. of the template), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the state is contracting with a group health plan or provides benefits through group health coverage, please describe briefly any limitations on pre-existing conditions. *Previously 8.6*

Section 6.4. States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. **(Section 2105(c)(2) and (3)) (457.1005 and 457.1010)**

X 6.4.1. Check here if the state is requesting **to provide cost-effective coverage through a community-based health delivery system.** This allows the state to waive the 10% limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(~~d~~c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the state must demonstrate that payments in excess of the 10% limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the state to administer the plan. **(42CFR, 457.1005(a))**

X 6.4.1.1. If a cost-effective alternative~~s~~ is sought,

coverage provided to targeted low-income children through such expenditures meet the coverage requirements as stated above and describe the coverage provided by the alternative delivery system in an attachment. **(Section 2105(c)(2)(B)(i)) (42CFR, 457.1005(b))**

X 6.4.1.2. If a cost-effective alternatives is sought, the cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described in 6.4.1., and describe the cost of such coverage on an average per child basis in an attachment. **(Section 2105(c)(2)(B)(ii)) (42CFR, 457.1005(b))**

X 6.4.1.3. If a cost-effective alternatives is sought, describe the community based delivery system in an attachment. **(Section 2105(c)(2)(B)(iii)) (42CFR, 457.1005(a))**

X 6.4.2. Check here if the state is requesting **to purchase family coverage.** Any state requesting to purchase such coverage will need to include information that establishes to the Secretary=s satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. **(Section 2105(c)(3)) (42CFR, 457.1010)**

X 6.4.2.1. Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children. Include a model of how cost effectiveness will be calculated. **(Section 2105(c)(3)(A)) (42CFR, 457.1010(a))**

X 6.4.2.2. Describe how the family coverage would not otherwise substitute for health insurance that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR, 457.1010(b))**

Section 7. Quality and Appropriateness of Care

Introduction

State child health plans must include a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for states= use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. Listed below are some of the methods which states may consider using. In addition to methods, there are a variety of tools available for state adaptation and use with this program. A list of some of these tools is provided below. States also have the option to choose who will conduct these activities. As an alternative to using staff of the state agency administering the program, states have the option to contract out with other organizations for this quality of care function.

Methods for Evaluating and Monitoring Quality

Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the state or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys to assess members= experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the state or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies could include the establishment of quality improvement goals for the plan or the state and provider education. Other strategies includes specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Tools for Evaluating and Monitoring Quality

Tools and types of information available include QARI (Medicaid=s Quality Assurance Review Initiative), QISMC (The Quality Improvement System for Managed Care) which is under development by CMS and will replace QARI, HEDIS (Health Employer Data Information Set) measures, FACCT (Foundation for Accountability) measures, CAHPS (Consumer Assessments of Health Plans Study), vital statistics data, and state health registries (e.g., immunization registries).

Quality monitoring may be done internally by appropriate staff of the state agency administering the child health insurance program or may be contracted out to a variety of entities including state Health Departments, external quality review organizations, PROs (Professional Review Organizations), and others with appropriate skills and expertise. Establishing grievance measures is also an important aspect of monitoring.

States are also expected to comply with any national quality measures developed in the future as discussed on page 2. Any standards that are adopted will be developed in conjunction with the states and other interested parties.

****Note: States electing to use funds provided under Title XXI only to provide expanded eligibility under the state=s Medicaid plan may check the appropriate box and proceed to Section 8.**

Guidance

Section 7.1. Provide a brief description of methods to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care and immunizations provided under the plan. The state must also specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards, QISMC or professional standards such as AAP=s. Any description of the information strategies used should be linked to section 9. **(2102(a)(7)(A)) (42CFR, 457.495)**

X 7.1.1.-7.1.4. Check each of the tools listed that the state plans to utilize to assure quality.

Section 7.2. Provide a brief description of methods to be used to assure access to covered services, including a description of how the state will assure the quality and appropriateness of the care provided. The state should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. **(2102(a)(7)(B))**

7.2.1 Well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations.**(Section 2102(a)(7)) (42CFR, 457.495(a))**

7.2.2 Emergency services as defined in 42 CFR ∋457.10. **(Section 2102(a)(7)) 42CFR, 457.495(b))**

7.2.3 Appropriate and timely procedures to monitor and treate enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee=s medical condition. **(Section 2102(a)(7)) (42CFR, 457.495(c))**

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR, 457.495(d))**

Section 8. Cost-Sharing and Payment

Introduction

This section addresses the requirement of a state child health plan to include a description of its proposed cost sharing for enrollees. Cost-sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost-sharing imposed. The cost-sharing requirements provide protection for lower income children in the state=s cost-sharing plan, ban cost-sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions.

****Note: States electing to use funds provided under Title XXI only to provide expanded eligibility under the state=s Medicaid plan may check the appropriate box and proceed to Section 9.**

Guidance

Section 8.1. Indicate if the state=s Title XXI plan will implement any sort of cost-sharing.

X	8.1.1. Check here if the state=s Title XXI plan will implement any sort of cost-sharing in the form of premiums, deductibles, coinsurance or other cost-sharing.
X	8.1.2. Check here if the state=s Title XXI plan will ***not*** implement any sort of cost-sharing. If there is no cost-sharing, proceed to question 8.8.

Section 8.2. This section asks for a description of the cost-sharing under the state plan. The description should include information on the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.

It is important to note that, for families below 150% of poverty, the same limitations on cost-sharing that are under the Medicaid program apply (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50-.59). For families with incomes of 150% of poverty and above, cost-sharing for all children in the family cannot exceed 5% of a family=s income per year. **(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))**

Section 8.3. Provide a brief description of how beneficiaries and the public will be able to obtain information on cost-sharing requirements, including the cumulative

maximum and any changes to these amounts.

Section 8.4. To ensure that protection will be provided for lower income children and that preventive services will not be subject to cost-sharing, the state must assure that the following are descriptive of its plan. The state should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

X 8.4.1. Under Title XXI, cost-sharing cannot favor children with higher incomes over those with lower incomes. Please indicate if the state=s plan follows this requirement.

X 8.4.2. Under Title XXI, state plans are not allowed to have cost-sharing on well-baby and well-child care, including age appropriate immunizations. Please indicate if the plan follows this requirement.

X 8.4.3 Under Title XXI, state plans are not allowed to impose additional cost-sharing for the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR, 457.515(f))**

The state should be able to demonstrate upon request its rationale and supporting justification regarding the assurances addressed above.

Section 8.5. Cost-sharing on children cannot exceed 5% of family income for the length of the child=s eligibility period in the state. Please provide a description of the methods that will be used to ensure that families will not be charged more than allowed. These methods should not primarily rely on a refund given by the state for overpayment by an enrollee

Section 8.6. This section asks for a description of the procedures the state will use to ensure that children from American Indian or Alaska Native families will be excluded from the imposition of premiums, deductibles, coinsurance, copayments or any other cost sharing charges.

Section 8.7. Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Based upon this provision in the statute, this section asks states to provide a brief description of the consequences for an enrollee or applicant who does not pay a charge. Please provide an assurance that the following disenrollment protections are being applied:

X The state has established a process that gives beneficiaries reasonable

notice of and an opportunity to pay past due cost sharing amounts (premiums, copayments, coinsurance, deductibles and similar fees) prior to disenrollment.

X The disenrollment process affords the enrollee an opportunity to show that the enrollee=s family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42CFR, 457.570(b))**

X In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child=s cost-sharing category as appropriate. **(42CFR, 457.570(b))**

X The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR, 457.570(c))**

Section 8.8 This section asks for assurances from the state that it has made the following findings with respect to the payment aspects of its plan. Check all that apply to your state=s plan. **(Section 2103(e))**

8.8.1. No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4))**

8.8.2. No premiums or cost-sharing will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR, 457.224)** (*Previously 8.4.5)*

8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42CFR, 457.626(a)(1))**

8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR, 457.310)**

8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR, 457.475)**

8.8.6. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR, 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Introduction

The section addresses the strategic objectives, the performance goals, and the performance measures the state has established for providing child health assistance to targeted low-income children under the plan for maximizing health benefits coverage for other low-income children and children generally in the state.

States are also expected to comply with any national performance measures developed in the future as discussed on page 2. Any standards that are adopted will be developed in conjunction with the states, advocacy groups, and other interested parties.

Guidance

Section 9.1. Identify and list the specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children. It is suggested the state identify a minimum of 5, but no more than 10 strategic objectives.

Section 9.2. Specify at least one performance goal and performance measure for each strategic objective. We plan on developing, in conjunction with the states, advocacy groups, and other interested parties, national standards for performance measures. We will be working with states to develop the most useful measures. In the interim, we are proposing examples that may be useful for states in designing their performance measures. In the hope of consistent reporting among states, and for the aggregation of national results, we suggest that each performance goal and performance measure be described as reflected in Section 9.3.

Section 9.3. Briefly describe how the plan=s performance will be measured objectively and independently. Check all appropriate measures the state will be utilizing.

It is acceptable for the state to include performance measures for population subgroups chosen by the state for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 3.0 measures directly relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children=s age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be

found in the HEDIS 3.0 manual published by the National Committee on Quality Assurance. So that state HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 3.0 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care. HEDIS 3.0 is a set of standardized performance measures designed for managed care plans, including plans that enroll Medicaid beneficiaries. HEDIS is intended to focus on areas of health important to individual consumers and patients, providers, and purchasers, and is being used by over 300 managed care plans to report performance experience for the reporting year 1996. Results by plan and summary results (national and regional) will be available in early fall 1997.

The following is an example of how the State could provide an objective measure.

HEDIS 3.0 Reporting Set Measures Relevant to Children and Adolescents

HEDIS *Domain* /Measure	Rough definition of Measure
Effectiveness of Care	
Childhood immunization status	% of children in plan who have received appropriate immunizations by their 2nd birthday
Adolescent immunization status	% of 13-year-olds in plan who received all appropriate immunizations by their 13th birthday
Treating children=s ear infections	How often a non-preferred antibiotic was given to children with uncomplicated acute otitis media
Access/Availability of Care	
Children=s access to primary care providers	% of Medicaid enrolled children age 12 months through 24 months and age 25 months through 6 years who had a visit with a health plan primary care provider during the reporting year, and the % of Medicaid enrolled children age 7 through 11 years who had a visit with a health plan primary care provider during the reporting year or the year preceding the reporting year.
Satisfaction with the Experience of Care	
CAHPS -child health module	
Use of Services	
Well-child visits in the first 15 months of life	% of members who turned 15 months old during the reporting year and who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care provider during their first 15 months of life.
Well-child visits in the Third, Fourth, Fifth and Sixth Year of Life	% of enrolled members who were 3, 4, 5, or 6 years old during the reporting year and who received one or more well-child visit(s) with a primary care provider during the reporting year.
Adolescent well-care visits	% of members who were age 12 through 21 years[1] during the reporting

[1] States receiving funds would be required to cover, and thus to use, this quality measure, only for children less than 19.	year who have had at least one comprehensive well-care visit with a primary care provider during the reporting year.
Health Plan Descriptive Information	
Pediatric physician specialists	% of each that has completed residency training or fellowship training in their respective specialties and/or are board certified, reported separately for each payer.
Pediatric mental health services	A narrative description of the health plan=s pediatric mental health provider network, including the number and types of MH providers specially trained to treat children and adolescents (including, but not limited to, child psychiatrists, child psychologists and social workers, counselors, marriage and family therapists and nurses with special education and training in child and adolescent mental health). If the plan subcontracts for this service, it is required to describe any special requirements included in the subcontracts.

Section 9.4. Assure that the state will provide reports to the Secretary as requested.

Section 9.5. Briefly describe the state=s plan for annual assessment and evaluation. (See section 10 and sections 2108 (a) of the Act.) Some questions to consider and to assist the state in describing the state=s plan for annual assessment include:

For the annual assessment:

X How will the state calculate the baseline number of uncovered low-income children?

Section 9.6. Self-explanatory

Section 9.7. As stated above, national performance standards will be developed in conjunction with states, advocates, and other interested parties. This assurance verifies that the states will participate in the collection and evaluation of data when the measures are developed.

Section 9.8. Assure that the state applies sections of this Act in the same manner as they apply under Title XIX as listed in Title XXI, Section 2107(e)(1). Check all that apply.

Section 9.9. Briefly describe the process and document the activity used to involve the public, including community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance

program.

9.9.1 Briefly describe the process the State officials responsible for SCHIP will use to interact with Tribes and other organizations in the State (such as regional Indian health boards, urban Indian health organizations, non-Federally recognized Tribes, and units of the Indian Health Service) on development and implementation of the procedures used to ensure the provision of child health assistance to American Indian or Alaska Native children.

9.9.2 Briefly describe the process used by the state to provide public notice regarding an amendment that restricts eligibility or benefits (includes cost sharing and enrollment procedures) under the state plan or plan amendment.

Section 9.10. A state plan, or plan amendment, that has a significant impact on the approved budget, must include a one-year budget. The budget must include: projected amount to be spent on health services; projected amount to be spent on administrative costs; and assumptions on which the budget is based. The budget should also show the projected sources of non-Federal plan expenditures, this includes any requirements for cost-sharing by enrollees. A suggested financial form for the budget is attached. This budget must be updated periodically as necessary.

Section 10. Annual Reports and Evaluations

Introduction and Guidance

Section 2108(a) requires the state to assess the operation of the State Child Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uncovered low-income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year.

In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box.

Section 10.1. These assurances address the annual assessment.

X A framework for the annual reports has been developed by the National Academy for State Health Policy (NASHP) working with CMS and the states. The framework is a voluntary tool states can use to complete the required evaluation report. The framework recognizes the diversity in state approaches to implementing SCHIP and provides consistency across states in the structure, content ,and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP=s website at http://www.nashp.org.

Section 10.2. Self -explanatory. States are also expected to comply with any national reporting measures developed in the future as discussed on page 2. Any standards that are adopted will be developed in conjunction with the states, advocacy groups, and other interested parties.

Section 10.3 Specify that the state agrees to the assurance that it will comply with all Federal laws and regulations, including grant administration and reporting rules.

Section 11. Program Integrity (Section 2101(a))

****Note: States electing to use funds provided under Title XXI only to provide expanded eligibility under the state=s Medicaid plan may check the appropriate box and proceed to Section 12.**

11.1 Check this box if the state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR, 457.940(b))**

11.2. This section asks the state to provide an assurance that, to the extent they apply, the provisions in section 2107(e) of the Social Security Act will apply under Title XXI to the same extent they apply to a state under Title XIX. Check all that apply. **(42CFR, 457.935(b))** *These items were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

****Note: States electing to use funds provided under Title XXI only to provide expanded eligibility under the state=s Medicaid plan may check the appropriate box.**

Eligibility and Enrollment Matters

12.1 This sections asks states to describe the review process for **eligibility and enrollment** matters, consistent with the requirements of 42 CFR ∋457.1120.

Health Services Matters

12.2 This sections asks states to describe the review process for **health services** matters, consistent with the requirements of 42 CFR ∋457.1120.

Premium Assistance Programs

12.3 This section applies only to states using a premium assistance program to provide coverage under a group health plan. If a participating group health plan **does not meet** the requirements of 42 CFR ∋457.1120, the state should describe how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan.

GLOSSARY

Adapted directly from SEC. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term `child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

(1) Inpatient hospital services.

(2) Outpatient hospital services.

(3) Physician services.

(4) Surgical services.

(5) Clinic services (including health center services) and other ambulatory health care services.

(6) Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

(7) Over-the-counter medications.

(8) Laboratory and radiological services.

(9) Prenatal care and prepregnancy family planning services and supplies.

(10) Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.

(11) Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.

(12) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).

(13) Disposable medical supplies.

(14) Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family

members, and minor modifications to the home).

(15) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.

(16) Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

(17) Dental services.

(18) Inpatient substance abuse treatment services and residential substance abuse treatment services.

(19) Outpatient substance abuse treatment services.

(20) Case management services.

(21) Care coordination services.

(22) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(23) Hospice care.

(24) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--

(A) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,

(B) performed under the general supervision or at the direction of a physician, or

(C) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

(25) Premiums for private health care insurance coverage.

(26) Medical transportation.

(27) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

(28) Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title--

(1) IN GENERAL- Subject to paragraph (2), the term `targeted low-income child' means a child--

(A) who has been determined eligible by the State for child health assistance under the State plan;

(B)(I) who is a low-income child, or

(ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and

(C) who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).

(2) CHILDREN EXCLUDED- Such term does not include--

(A) a child who is a resident of a public institution or a patient in an institution for mental diseases; or

(B) a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.

(3) SPECIAL RULE- A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.

(4) MEDICAID APPLICABLE INCOME LEVEL- The term `medicaid applicable income level' means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under section 1902(l)(2) for the age of such child.

ADDITIONAL DEFINITIONS- For purposes of this title:

(1) CHILD- The term `child' means an individual under 19 years of age.

(2) CREDITABLE HEALTH COVERAGE- The term `creditable health coverage' has the meaning given the term `creditable coverage' under section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).

(3) GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC- The terms `group health plan', `group health insurance coverage', and `health insurance coverage' have the meanings given such terms in section 2191 of the Public Health Service Act.

(4) LOW-INCOME CHILD - The term `low-income child' means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.

(5) POVERTY LINE DEFINED- The term `poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

(6) PREEXISTING CONDITION EXCLUSION- The term `preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).

(7) STATE CHILD HEALTH PLAN; PLAN- Unless the context otherwise requires, the terms `State child health plan' and `plan' mean a State child health plan approved under section 2106.

(8) UNCOVERED CHILD- The term `uncovered child' means a child that does not have creditable health coverage.'.